

TRANSMITTAL AND NOTICE OF APPROVAL
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**ORIGINAL**

1. TRANSMITTAL NUMBER:

2. STATE:

1 - 0 - 0 - 2

Idaho

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

04/01/01

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAR 16 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 441.35

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 100,000

b. FFY 2002 \$ 100,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A 1 & 2
Attachment 3.1-A 5.a.
Attachment 3.1-E page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 3.1-A 1 & 2
Attachment 3.1-A 5.a.
Attachment 3.1-E page 1

10. SUBJECT OF AMENDMENT:

Adds intestinal transplants to the list of covered transplant procedures. Limits outpatient physical therapy visits and other technical changes.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

KARL B. KURTZ

14. TITLE:

Director

15. DATE SUBMITTED:

March 13, 2001

16. RETURN TO:

JOSEPH R. BRUNSON
IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID
P.O. BOX 83720
BOISE ID 83720-0036**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

MAR 16 2001

18. DATE APPROVED:

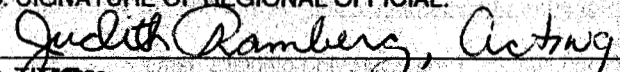
APR - 9 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

APR - 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

TERESA L. TRIMBLE

22. TITLE
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

"POSTMARKED: 3/14"
(DATE)BOISE
(CITY/STATE)

3.1-A Amount, duration and scope of medical and remedial care and services provided:

1. Inpatient Hospital Services: Necessary inpatient hospital care is limited to forty (40) days of hospital care until July 1, 1987. Subsequent to July 1, 1987, no limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Payment is limited to semiprivate room accommodations unless private accommodations are medically necessary and ordered by the physician.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Excluded Services: Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by Medicare program are excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval and by the Department.

Acupuncture, biofeedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

For transplant coverage, see Attachment 3.1-E.

The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department or its designee is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

TN#: 01-002

Approval Date: A-9-01

Supersedes TN#: 96-007

Effective Date: 4/1/01

2. a. Outpatient Hospital Services: Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Refer to items 3.1-A-1 and 5 for excluded services and information concerning abortion services.

Excluded Services: Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation. Visits by occupational therapists are limited to a total of one hundred (100) visits per recipient calendar year. Visits by physical therapists are limited to twenty-five (25) visits per calendar year unless preauthorized by the Department. Psychotherapy services are limited to forty-five (45) hours per calendar year. Partial care services are limited to fifty-six (56) hours per week per eligible recipient. Psychological evaluation, speech and hearing evaluations, physical therapy evaluation, and occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year. Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

- b. Rural Health Clinics: Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code. Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.
- c. Federally Qualified Health Centers: Federally qualified health centers provided within the scope, amount, and duration of the State's medical assistance program as described under Subsection 16.03.09.144 of the state of Idaho's Rules Governing Medical Assistance.

3. Other Laboratory and X-ray Services: Other laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services: Laboratory and/or x-ray procedures which are associated with excluded services found in Sections 3.1-A.1 and 3.1-A.5 of this plan are excluded from payment.

TN#: 01-002

Approval Date: 4-9-01

Supersedes TN#: 97-002

Effective Date: 4/1/01

5. a. Physician Services: The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations Sections 16.03.09.065 and 16.03.09.070.02, and listed below.

Excluded Services: Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by the Medicare program are excluded from Medicaid payment. Non-medically necessary cosmetic surgery is excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval by the Department.

Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy are excluded from Medicaid payment.

Procedures, counseling, office exams and testing for the inducement of fertility are excluded from Medicaid payment.

For transplant coverage, see Attachment 3.1-E.

Drugs supplied to patients for self-administration other than those allowed under Idaho Department and Welfare Rules and Regulations Section 03.9126 are excluded from Medicaid payment.

The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department or its designee, is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as part of a vision exam). Individuals with a diagnosis of Glaucoma are excluded from this limitation.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

TN #: 01-002

Supersedes TN#: 96-007

Approval Date:

Effective Date: 4/1/01

4-9-01

Revision: HCFA-PM-87-4 (BERC)
March 1987

Attachment 3.1-E
Page 1
OMB No. 0938-0193

State/Territory: Idaho Dept Health & Welfare

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Pursuant to the provisions of subsections 16.03.09.081 of the State's Rules Governing Medical Assistance, the Department may purchase organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers. Individuals under twenty-one (21) years of age qualifying under the State Plan in Attachment 3.1-A.4.b.vi.k., which describes waivers in coverage exclusions for EPSDT, may receive single or double lung, or combined heart-lung transplants from Medicare certified transplant centers.

TN#: 01-002

Approval Date: 4-9-01

Supersedes TN#: 95-008

Effective Date: 4/1/01